



## STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

### PART I - ADMINISTRATIVE

1. STATE HOME FACILITY		2. DATE ADMITTED (MM/DD/YYYY)	
3. STATE HOME FACILITY ADDRESS (Street, City, State and Zip Code)			
4. RESIDENT'S NAME (Last, First, Middle)			
5. SOCIAL SECURITY NUMBER	6. GENDER <input type="checkbox"/> M <input type="checkbox"/> F	7. AGE	8. DATE OF BIRTH (MM/DD/YYYY)
		9. ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> YES	
10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <b>10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH</b>			

### PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)

11. HISTORY								
12. HEIGHT	13. WEIGHT	14. TEMP	15. PULSE	16. BP	17. HEAD/EYES/EAR/NOSE AND THROAT			
18. NECK				19. CARDIOPULMONARY				
20. ABDOMEN				21. GENITOURINARY				
22. RECTAL				23. EXTREMITIES				
24. NEUROLOGICAL				25. ALLERGY/DRUG SENSITIVITY				
26. X-RAY/ LAB	CHEST X-RAY	DATE (MM/DD/YYYY)	RESULT	<input type="checkbox"/> N/A	CBC	DATE (MM/DD/YYYY)	RESULT	<input type="checkbox"/> N/A
	SEROLOGY							<input type="checkbox"/> N/A
	URINALYSIS	DATE (MM/DD/YYYY)	ALBUMIN	ACETONE		SUGAR		<input type="checkbox"/> N/A

#### CHECK ALL BOXES THAT APPLY OR CHECK N/A

27. IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	30. IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
31. IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS: <input type="checkbox"/> SCHIZOPHRENIA <input type="checkbox"/> PARANOIA <input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY <input type="checkbox"/> MOOD SWINGS <input type="checkbox"/> SOMATOFORM DISORDER <input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER <input type="checkbox"/> PERSONALITY DISORDER <input type="checkbox"/> N/A			
32. OXYGEN <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> CONTINUOUS <input type="checkbox"/> NASAL CANNULA <input type="checkbox"/> N/A	33. FEEDING <input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHEOSTOMY <input type="checkbox"/> N/A	34. WOUND <input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED <input type="checkbox"/> N/A	35. FOLEY CATHETER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT <input type="checkbox"/> N/A
36. REFERRING PHYSICIAN		37. PRIMARY DIAGNOSIS	
38. SECONDARY DIAGNOSIS		39. TERTIARY DIAGNOSIS	
40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			
41. TYPE OF CARE RECOMMENDED: <input type="checkbox"/> SKILLED NURSING HOME CARE <input type="checkbox"/> DOMICILIARY CARE <input type="checkbox"/> ADULT DAY HEALTH CARE			
42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY			
43. PRINTED OR TYPED NAME OF SVH PHYSICIAN/APRN/PA		44. SIGNATURE OF SVH PHYSICIAN/APRN/PA <b>NOTE:</b> This field cannot be signed without first filling out item numbers 36 through 43. After signing, all fields in Part 2 will become locked and read only.	

**PART III - EVALUATION (Select an appropriate number in each category)**

45. RESIDENT'S NAME (Last, First, Middle)

46. SOCIAL SECURITY NUMBER

<b>COMMUNICATION</b>	<input type="checkbox"/> 1. Transmits messages/receives information <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Nearly or totally unable	<b>SPEECH</b>	<input type="checkbox"/> 1. Speaks clearly with others of same language <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Unable to speak clearly or not at all
<b>HEARING</b>	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Hearing slightly impaired <input type="checkbox"/> 3. Nearly or totally unable <input type="checkbox"/> 4. Virtually/completely deaf	<b>SIGHT</b>	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Vision adequate - Unable to read/see details <input type="checkbox"/> 3. Vision limited - Gross object differentiation <input type="checkbox"/> 4. Blind
<b>TRANSFER</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Equipment only <input type="checkbox"/> 3. Supervision only <input type="checkbox"/> 4. Requires human transfer w/wo equipment <input type="checkbox"/> 5. Bedfast	<b>AMBULATION</b>	<input type="checkbox"/> 1. Independence w/wo assistive device <input type="checkbox"/> 2. Walks with supervision <input type="checkbox"/> 3. Walks with continuous human support <input type="checkbox"/> 4. Bed to chair (total help) <input type="checkbox"/> 5. Bedfast
<b>ENDURANCE</b>	<input type="checkbox"/> 1. Tolerates distances (250 feet sustained activity) <input type="checkbox"/> 2. Needs intermittent rest <input type="checkbox"/> 3. Rarely tolerates short activities <input type="checkbox"/> 4. No tolerance	<b>MENTAL AND BEHAVIOR STATUS</b>	<input type="checkbox"/> 1. Alert <input type="checkbox"/> A. Agreeable <input type="checkbox"/> 2. Confused <input type="checkbox"/> B. Disruptive <input type="checkbox"/> 3. Disoriented <input type="checkbox"/> C. Apathetic <input type="checkbox"/> 4. Comatose <input type="checkbox"/> D. Well motivated
<b>TOILETING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Assistance to and from transfer <input type="checkbox"/> A. Bathroom <input type="checkbox"/> 3. Total assistance including personal hygiene, help with clothes <input type="checkbox"/> B. Bedside commode <input type="checkbox"/> <input type="checkbox"/> C. Bedpan	<b>BATHING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> A. Tub <input type="checkbox"/> 2. Supervision Only <input type="checkbox"/> B. Shower <input type="checkbox"/> 3. Assistance <input type="checkbox"/> C. Sponge bath <input type="checkbox"/> 4. Is bathed
<b>DRESSING</b>	<input type="checkbox"/> 1. Dresses self <input type="checkbox"/> 2. Minor assistance <input type="checkbox"/> 3. Needs help to complete dressing <input type="checkbox"/> 4. Has to be dressed	<b>FEEDING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Minor assistance, needs tray set up only <input type="checkbox"/> 3. Help feeding/encouraging <input type="checkbox"/> 4. Is fed
<b>BLADDER CONTROL</b>	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Catheter, indwelling	<b>BOWEL CONTROL</b>	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Ostomy
<b>SKIN CONDITION</b>	<input type="checkbox"/> 1. Intact <input type="checkbox"/> 2. Dry/Fragile <input type="checkbox"/> 3. Irritations (Rash) <input type="checkbox"/> 4. Open wound <input type="checkbox"/> 5. Decubitus	<b>WHEEL CHAIR USE</b>	<input type="checkbox"/> 1. Independence <input type="checkbox"/> 2. Assistance in difficult maneuvering <input type="checkbox"/> 3. Wheels a few feet <input type="checkbox"/> 4. Unable to use <input type="checkbox"/> N/A

47. SIGNATURE OF REGISTERED NURSE OR PHYSICIAN/APRN/PA

NOTE: After signing, all fields in Part 3 will become locked and read only.

48. DATE (MM/DD/YYYY)

**PHYSICAL THERAPY (To be completed by Physical Therapist or Physician/APRN/PA)** 49. Check if  NEW REFERRAL  CONTINUATION OF THERAPY  N/A

50. SENSATION IMPAIRED <input type="checkbox"/> YES <input type="checkbox"/> NO	51. RESTRICT ACTIVITY <input type="checkbox"/> YES <input type="checkbox"/> NO	52. PRECAUTIONS <input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER (Type other, specify)	53. FREQUENCY OF TREATMENT
54. TREATMENT GOALS: <input type="checkbox"/> ACTIVE	<input type="checkbox"/> COORDINATING ACTIVITIES	<input type="checkbox"/> FULL WEIGHT BEARING	<input type="checkbox"/> WHEELCHAIR INDEPENDENT
<input type="checkbox"/> STRETCHING	<input type="checkbox"/> ACTIVE ASSISTIVE	<input type="checkbox"/> NON-WEIGHT BEARING	<input type="checkbox"/> COMPLETE AMBULATION
<input type="checkbox"/> PASSIVE ROM	<input type="checkbox"/> PROGRESSIVE RESISTIVE	<input type="checkbox"/> PARTIAL WEIGHT BEARING	<input type="checkbox"/> RECOVERY TO FULL FUNCTION

55. ADDITIONAL THERAPIES  
 O.T.  SPEECH  DIETARY

56. SIGNATURE OF AND TITLE OF THERAPIST OR PHYSICIAN/APRN/PA  
NOTE: After signing, all fields under Physical Therapy will become locked and read only.

57. DATE (MM/DD/YYYY)

**PART IV - SOCIAL WORK ASSESSMENT (To be completed by SVH Social Worker (SW) or Physician/APRN/PA)**

58. PRIOR LIVING ARRANGEMENTS	59. LONG RANGE PLAN
60. ADJUSTMENT TO ILLNESS OR DISABILITY, LIVING ENVIRONMENT AND MAKE COMPETENT DECISIONS	61. PRINT NAME OF SW OR PHYSICIAN/APRN/PA
62. SIGNATURE OF SW OR PHYSICIAN/APRN/PA NOTE: After signing, all fields in Part 4 will become locked and read only.	63. DATE (MM/DD/YYYY)
64. REMARKS (Attach additional sheets if necessary)	

**PART V - VA AUTHORIZATION FOR PAYMENT**

 65. RESIDENT'S NAME *(Last, First, Middle)*

66. SOCIAL SECURITY NUMBER

**ADMINISTRATIVE REVIEW**
**CLINICAL REVIEW**

 67. 10-10EZ OR 10-10EZR HAS BEEN RECEIVED WITH 10-10SH:  
 YES  NO  N/A (ELECTRONIC VERSION COMPLETED)

 74. IS VETERAN BEING ADMITTED DUE TO SC CONDITION?  
 YES  NO

 68. DATE ADMITTED TO SVH  
*(MM/DD/YYYY):*

 69. DATE RECEIVED BY VA  
*(MM/DD/YYYY):*

75. SERVICE CONNECTED CONDITION BEING ADMITTED FOR:

 70. VETERAN ELIGIBLE FOR PER DIEM PAYMENT:  
 BASIC  PREVAILING  NO

**NURSING HOME CARE**

 71. REMARKS *(Attach additional sheets if necessary):*

 76. VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE:  
 YES  NO

**DOMICILIARY CARE *(See Instructions for Clarification)***

 77. DOES VETERAN HAVE "NO ADEQUATE MEANS OF SUPPORT"?  
 YES  NO *(If checked yes, qualifies Veteran for per diem payment)*

 78. VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE:  
 YES  NO *(If checked yes, Veteran must meet all eight ADLs)*
**ADULT DAY HEALTH CARE *(See Instructions for Clarification)***

 79. IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE?  
 YES  NO

 80. VETERAN APPROVED FOR ADULT DAY HEALTH CARE:  
 YES  NO

81. REMARKS:

**NOTE:** After signing, all fields in Part 5, Administrative Review will become locked and read only.

**NOTE:** After signing, all fields in Part 5, Clinical Review, Nursing Home Care, Domiciliary Care, and Adult Day Health Care will become locked and read only.

72. SIGNATURE OF VA ADMINISTRATIVE REVIEWER

 73. DATE  
*(MM/DD/YYYY)*

82. SIGNATURE OF VA PHYSICIAN/APRN/PA

 83. DATE  
*(MM/DD/YYYY)*
**PAPERWORK REDUCTION ACT OF 1995 AND PRIVACY ACT STATEMENT**

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by who must complete this form will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

**Privacy Act Information:** The information requested on this form is solicited under the authority of Title 38, U.S.C. Sections 1741, 1743 and 1745. It is being collected to enable us to determine eligibility for health benefits in the State Home Program and will be used for that purpose. The information you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which the Veteran may be entitled. The disclosure of Social Security Number; VA will use it to administer VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

As a condition for VA approved State Veterans Home (SVH) to receive payment of per diem, the State Home must submit to the VA Medical Center of jurisdiction for each Veteran a completed VA Form 10-10SH, State Home Program Application for Care Medical Certification and a 10-10EZ, Application for Health Benefits or 10-10EZR, Health Benefits Update Form. Use additional sheets if needed containing the Veteran's name and Social Security Number. If you need more room to respond to a question, write "Continuation of Item" and write the section and question number.

**PART I - ADMINISTRATIVE**

**This section must be completed in full by State Veterans Home designated staff.**

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|---|---|
| <ol style="list-style-type: none"> <li>1. STATE HOME FACILITY - Enter the name of the facility</li> <li>2. DATE ADMITTED - Select the date admitted using the calendar or enter the date as MM/DD/YYYY</li> <li>3. STATE HOME FACILITY ADDRESS - Enter complete address</li> <li>4. RESIDENT'S NAME - Enter the full name of the person to whom this application applies</li> <li>5. SOCIAL SECURITY NUMBER - Enter the full social security number of the applicant</li> </ol> | <ol style="list-style-type: none"> <li>6. GENDER - Check the appropriate box</li> <li>7. AGE - Age of applicant</li> <li>8. DATE OF BIRTH - Enter the date of birth in the format MM/DD/YYYY</li> <li>9. ADVANCED MEDICAL DIRECTIVE - Check No or Yes</li> <li>10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS? Check Yes, No, or N/A.<br/><b>10-10EZ or 10-10EZR is required to be submitted either in paper form or electronically with the 10-10SH. Note: N/A is used for admission application for NHC and ADHC.</b></li> </ol> |
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**PART II - HISTORY AND PHYSICAL**

This section must be completed in full by State Veterans Home designated staff. The completed VA Form 10-10SH must contain sufficient medical information to justify the level of care that is to be provided to the Veteran. Failure to submit or complete this form correctly may result in denial or delay of VA per diem payment.

- |  |  |
|--|--|
| <ol style="list-style-type: none"> <li>11. HISTORY - Enter the patient background and history</li> <li>12. HEIGHT - Enter the applicant's height</li> <li>13. WEIGHT - Enter the applicant's weight</li> <li>14. TEMP - Enter the applicant's temperature</li> <li>15. PULSE - Enter the applicant's pulse rate</li> <li>16. BP - Enter the applicant's blood pressure</li> <li>17. HEAD/EYES/EARS/NOSE AND THROAT - Enter any problems with the head, eyes, ears, nose and throat or N/A</li> <li>18. NECK - Enter any problems with the neck or N/A</li> <li>19. CARDIOPULMONARY - Enter any problems with the heart or N/A</li> <li>20. ABDOMEN - Enter any problems with the abdomen or N/A</li> <li>21. GENITOURINARY - Enter any problems with the genitourinary system or N/A</li> <li>22. RECTAL - Enter any problems with the rectum or N/A</li> <li>23. EXTREMITIES - Enter any problems with the extremities or N/A</li> <li>24. NEUROLOGICAL - Enter any problems neurologically or N/A</li> <li>25. ALLERGY/DRUG SENSITIVITY - Enter any allergies or sensitivities or N/A</li> <li>26. X-RAY/LAB - Date of chest x-ray, results; CBC date, result; serology; urinalysis date, albumin, sugar, acetone or N/A</li> <li>27. IS DEMENTIA THE PRIMARY DIAGNOSIS? Check Yes, No or N/A (not applicable)</li> <li>28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS? Check Yes, No or N/A (not applicable)</li> </ol> | <ol style="list-style-type: none"> <li>29. HAS THE RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS? Check Yes, No or N/A (not applicable)</li> <li>30. IS CLIENT A DANGER TO SELF OR OTHERS? Check Yes, No or N/A (not applicable)</li> <li>31. IS THERE ANY PRESSING EVIDENCE OR MENTAL ILLNESS SUCH AS - Check all that apply or check N/A</li> <li>32. OXYGEN - Check all that apply or check N/A</li> <li>33. FEEDING - Check all that apply or check N/A</li> <li>34. WOUND - Check all that apply or check N/A</li> <li>35. FOLEY CATHETER - Check all that apply or check N/A</li> <li>36. REFERRING PHYSICIAN - Enter the name of the referring physician</li> <li>37. PRIMARY DIAGNOSIS - Enter the primary diagnosis</li> <li>38. SECONDARY DIAGNOSIS - Enter the secondary diagnosis</li> <li>39. TERTIARY DIAGNOSIS - Enter the tertiary diagnosis</li> <li>40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? Check Yes, No or Unknown</li> <li>41. TYPE OF CARE RECOMMENDED - Choose the appropriate care</li> <li>42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY - Enter all medications and treatment orders on the applicant.</li> <li>43. PRINTED OR TYPED NAME OF SVH PHYSICIAN/APRN/PA - Print or Type name of SVH Physician, or Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA)</li> <li>44. SIGNATURE OF SVH PHYSICIAN/APRN/PA - Enter signature</li> </ol> |
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**PART III - EVALUATION (To be completed by SVH)**

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| <ol style="list-style-type: none"> <li>45. RESIDENT'S NAME - Enter the full name of the person in which this application applies</li> <li>46. SOCIAL SECURITY NUMBER - Enter the full social security number of the applicant</li> <li>47. SIGNATURE OF REGISTERED NURSE OR PHYSICIAN/APRN/PA - Enter signature</li> <li>48. DATE - Enter date signed by registered nurse or Physician/APRN/PA</li> </ol> <p><u>PHYSICAL THERAPY</u></p> <ol style="list-style-type: none"> <li>49. Check the box if new or continued therapy or N/A</li> <li>50. SENSATION IMPAIRED? Check Yes or No</li> </ol> | <ol style="list-style-type: none"> <li>51. RESTRICT ACTIVITY? Check Yes or No</li> <li>52. PRECAUTIONS - Check if there is a cardiac or other (for other type over the text in the box)</li> <li>53. FREQUENCY OF TREATMENT - Enter how often the applicant receives physical therapy</li> <li>54. TREATMENT GOALS - Check all that apply</li> <li>55. ADDITIONAL THERAPIES - Check all that apply</li> <li>56. SIGNATURE AND TITLE OF THERAPIST OR PHYSICIAN/APRN/PA - Enter signature</li> <li>57. DATE - Enter the date the Therapist or Physician signed (format MM/DD/YYYY)</li> </ol> |
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**PART IV - SOCIAL WORK ASSESSMENT (To be completed by SVH Social Worker (SW) or Physician/APRN/PA)**

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|--|---|
| <p>58. PRIOR LIVING ARRANGEMENTS</p> <p>59. LONG RANGE PLAN</p> <p>60. ADJUSTMENT TO ILLNESS OR DISABILITY, LIVING ENVIRONMENT AND MAKE COMPETENT DECISIONS - Explain Veteran's ability to adjust to their illness/disability, living environment and make competent decisions</p> | <p>61. PRINT NAME OF SW OR PHYSICIAN/APRN/PA - Print or type name of Social Worker (SW) or Physician/APRN/PA</p> <p>62. SIGNATURE OF SW OR PHYSICIAN/APRN/PA - Enter signature</p> <p>63. DATE</p> <p>64. REMARKS</p> |
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**PART V - VA AUTHORIZATION FOR PAYMENT**

Completed in full by VA Medical Center of Jurisdiction designated staff

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|---|---|
| <p>65. RESIDENT'S NAME - Enter the full name of the person in which this application applies</p> <p>66. SOCIAL SECURITY NUMBER - Enter the full social security number of the applicant</p> <p><u>ADMINISTRATIVE REVIEW SECTION</u></p> <p>67. 10-10EZ OR 10-10EZR RECIEVED WITH 10-10SH - Check the appropriate if the forms were received with the 10-10SH or if the forms were completed electronically.</p> <p>68. DATE ADMITTED TO SVH - Enter the date the Veteran was physically admitted to the State Veteran's Home</p> <p>69. DATE RECEIVED BY VA - Enter the date the complete admission application was received by the VA.</p> <p>70. VETERAN ELIGIBLE FOR PER DIEM PAYMENT - Check either Basic or Prevailing for eligible Veteran; or No if not eligible. Veteran is eligible if they are not barred from receiving VA pension, compensation or dependency and indemnity compensation based on the character of a discharge from military service. For Domiciliary Care, Veteran's income from the 10-10EZ must meet the Aid and Attendance threshold or determination for Domiciliary Care is made by Clinical Reviewer. For ADHC, Veteran must be enrolled in the VA health care system at the time of the application.</p> <p>71. REMARKS - Enter any remarks regarding Administrative Review section. If Veteran is not eligible, enter reason per diem is denied.</p> <p>72. SIGNATURE OF VA ADMINISTRATIVE REVIEWER - Enter signature.</p> <p>73. DATE - Date of Administrative Reviewer's signature.</p> <p><u>CLINICAL REVIEW SECTION</u></p> <p>74. IS VETERAN BEING ADMITTED DUE TO SC CONDITION? Check YES or NO.</p> <p>75. SERVICE CONNECTED CONDITION BEING ADMITTED FOR - If necessary, review VA databases such as VISTA, HINQ, VIS, VBMS, or CPRS for Veteran's service-connection condition/rating. If the reason the Veteran is being admitted for nursing home or adult day health care for a SC condition, enter the service-connected condition the Veteran is being admitted for.</p> <p><u>NURSING HOME CARE</u></p> <p>76. VETERAN APPROVED FOR NURSING HOME LEVEL OF CARE - Check YES or NO.</p> <p><u>DOMICILIARY CARE</u></p> <p>77. DOES VETERAN HAVE "NO ADEQUATE MEANS OF SUPPORT" - For purposes of domiciliary care, "no adequate means of support" refers to an applicant whose annual income exceeds the rate of pension described in 38 CFR 51.51, but who is able to demonstrate to VA medical authority, on the basis of objective evidence, that deficits in health or functional status render the applicant incapable of pursuing substantially gainful employment, and who is otherwise without the means to provide adequately for himself or herself, or be provided for in the community. Check "Yes" for Veteran who has deficits in health or functional status rendering the applicant incapable of pursuing substantially gainful employment, and who is otherwise without the means to provide adequately for himself or herself, or be provided for in the community. Check "No" for Veteran who do not qualify for per diem.</p> | <p>78. VETERAN APPROVED FOR DOMICILIARY LEVEL OF CARE - Is Veteran capable of performing the following daily living activities?</p> <p>(1) Perform without assistance daily adulations, such as brushing teeth, bathing, combing hair, and body eliminations.</p> <p>(2) Dress self, with minimum of assistance.</p> <p>(3) Proceed to and return from the dining hall without aid.</p> <p>(4) Feed self.</p> <p>(5) Secure medical attention on an ambulatory basis or by use of personally propelled wheelchair.</p> <p>(6) Have voluntary control over body eliminations or control by use of an appropriate prosthesis.</p> <p>(7) Participate in some measure, however slight, in work assignments that support the maintenance and operation of the State home.</p> <p>(8) Make rational and competent decisions as to his or her desire to remain or leave the facility.</p> <p>If all the above conditions are met, check "Yes" in the appropriate box. If these conditions are not met, check "No". If any of the above questions are answered "No", per diem is not approved.</p> <p><u>ADULT DAY HEALTH CARE</u></p> <p>79. IF NOT ENROLLED IN ADHC, WILL VETERAN REQUIRE NURSING HOME CARE? Check YES or NO. Would Veteran require nursing home care and need adult day health care; and must meet any one of the following conditions:</p> <p>(1) The veteran has three or more Activities of Daily Living (ADL) dependencies.</p> <p>(2) The veteran has significant cognitive impairment.</p> <p>(3) The veteran has two ADL dependencies and two or more of the following conditions: (i) Seventy-five years old or older; (ii) High use of medical services, <i>i.e.</i>, three or more hospitalizations per calendar year, or 12 or more visits to an outpatient clinic or to an emergency evaluation unit per calendar year; (iii) Diagnosis of clinical depression; or (iv) Living alone in the community.</p> <p>(4) The veteran does not meet the criteria in 38 CFR 51.52, but nevertheless a licensed VA medical practitioner determines the veteran needs adult day health care services.</p> <p>80. VETERAN APPROVED FOR ADULT DAY HEALTH CARE - Check YES or NO.</p> <p>81. REMARKS - Enter any remarks regarding Clinical Review section to include justification for per diem denial.</p> <p>82. SIGNATURE OF VA PHYSICIAN/APRN/PA - Enter Signature of VA Physician, or Advanced Practice Registered Nurse (APRN), or Physician Assistant (PA).</p> <p>NOTE: VA clinician signature in block 82 indicates approval of level of care recommended by SVH physician in block 41. However, if the VA Clinician do not agree with the SVH Physician level of care recommendation, then per diem is not approved and denial letter must be sent to the State Home with Appeal Rights.</p> <p>83. DATE - Date of VA Physician, or APRN, or PA signature.</p> |
|---|---|